My Joints Are Killing Me! Opioids vs. NSAIDs for Chronic Pain - Frankly Speaking EP 68

Transcript Details

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Dr. Frank Domino:

Bill is a retired farmer in your practice, and he comes in today telling you his right knee is killing him. Bill has severe osteoarthritis of both knees, but in particular, the right knee is bad. To complicate matters, Bill's BMI is 33. He has tried various medications on and off in the past, and seems to get some benefit from them, but right now, his knee pain has really flared up. You've discussed surgery with Bill, but he's afraid of it, but he does point out that his brother, who also has severe osteoarthritis, was recently given a new medicine, oxy-something, that seems to really make him feel better. Bill wants to know if you'll be willing to give him this today. Hi, this is Frank Domino, and joining me today is Alan Ehrlich. Alan is an Associate Professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, and Executive Editor at DynaMed. Alan, thanks for coming today.

Dr. Alan Ehrlich:

Thanks for having me, Frank.

Dr. Domino:

Wow, so osteoarthritis of the knee, this is a very common problem, and as our population

ages, we have to come to grips with what the best evidence says about its management. Can you give us any thoughts about what the current state of affairs are regarding treatment for severe osteoarthritis?

Dr. Ehrlich:

Osteoarthritis should first be managed with non-pharmacologic approaches, and for someone who's overweight, that would certainly involve weight loss, and for anyone, it involves some type of physical activity regimen. Typically, you wanna do strengthening of the muscles around the affected joint, in this case, the knee, you wanna make sure you have good thigh strength. And secondly, you want to make sure they're engaging in some type of aerobic activity, either land-based or aquatic-based. For people with knee osteoarthritis, often aquatic-based forms of aerobic exercise are very helpful and they don't put any kind of stress on the joint.

Dr. Domino:

That's great. I think they're particularly helpful, especially in patients because as their arthritis worsens, they tend to do less, their muscles atrophy more, and getting them into an aerobics or some sort of exercise program is always a challenge.

Dr. Ehrlich:

So if that doesn't work, pharmacologic treatments, and they can be done in conjunction at the same time, are the next approach. Certainly, you'd wanna start with acetaminophen or possibly NSAIDs. In older populations, you often wanna stay away from NSAIDs because of either renal problems or GI toxicity, but you can certainly treat... Manage the pain with both of those. Those are both considered first-line options. If that doesn't work and people are having persistent pain, intra-articular corticosteroid injections are a reasonable option. You can also consider topical capsaicin, can be effective, and in some patients you might

consider low-dose oral corticosteroids, though that probably is best for a short period of time, given the potential toxicity of that.

Dr. Domino:

Any thoughts about hyaluronic acid injections?

Dr. Ehrlich:

Well, these may have some very short-term benefit. They don't seem to be effective in the long run, and the American Academy of Orthopedic Surgeons doesn't endorse its use.

Dr. Domino:

Alright, so we've talked about some non-pharmacologic and some pharmacologic interventions. You mentioned you talked to Bill about joint replacement, and he's hesitant. Where do we go from here?

Dr. Ehrlich:

Well, many patients who have persistent severe pain ultimately come in and are considering or looking for anything that... In the form of pain relief. And when they think of pain relief, they often think of narcotics, some kind of chronic opioid. There was a recent randomized trial that looked at the use of opioids in this type of population. That was the SPACE trial, and what they did was they looked at 240 patients who had either chronic low back pain, chronic knee or hip pain from osteoarthritis. And they had to have the pain for at least six months, and the pain was at least five out of 10, and so moderate severity. What they did in this trial was they randomized the groups to one of two approaches, both approaches were to target to pain and function improvement, and one was an opioid-based approach, and the other was a non-opioid-based approach. The non-opioid-based approach started with acetaminophen or NSAIDs, if that was ineffective, they could

progress to using medications for chronic pain such as anti-depressants or gabapentin. And if that was ineffective, they could progress to medications...

This was in a VA system that these third-line medications required prior authorization, and would involve either duloxetine, or tramadol, or something like that. On the opioid side of things, they started either with immediate-release morphine or hydrocodone-acetaminophen. If that wasn't effective, they progressed to sustained-release morphine or sustained-release oxycodone. And then finally fentanyl patches would be the third line for that group.

Dr. Domino:

And what did it find?

Dr. Ehrlich:

Well, it found that, after 12 months... And they were monitoring the patients throughout the course of the trial, the level of function and... Was no better with opioids than with the non-opioid therapy. In fact, the pain intensity over 12 months was actually better in the non-opioid group.

Dr. Domino:

The pain control... The pain control improved more.

Dr. Ehrlich:

Yes, I'm sorry. There was better pain control in the non-opioid group than there was in the opioid group, despite pain control being the primary virtue of opioids.

Dr. Domino:

Wow! That's quite remarkable. So what are we gonna do with Bill? We've gotta try to get him to a place where he can be functional.

Dr. Ehrlich:

For someone like Bill, he's probably a good candidate for an intra-articular corticosteroid injection right now. That often provides very quick relief. You can't do this on a long-term basis; in terms of the frequency, probably no more often than every three months for injections. But you could give him an injection right now and it might give him some relief. You wanna make sure he's optimized the non-pharmacologic approaches such as weight loss and exercise, those take longer, and he's looking for some type of immediate relief. One thing to keep in mind is that pain tends to wax and wane. And so, when people come in, they're usually at their worst and whatever you do, they're often going to get better because they would have gotten better anyhow. And so you need to keep that in mind. That's particularly true when starting opioids. If we got to a point where there was no other way to control Bill's pain, and we wanted to give him some opioids, it would make sense to use it for a very short-term basis. And I think the results of the SPACE trial show that initiating long-term opioid use is not going to be helpful.

The tricky part is that if you give someone opioids and they get prompt relief of their pain, there's going to be a strong temptation for them to keep wanting to use it over and over again, so they have to be educated about the limitations of opioids when used chronically. And I think the study points out that certainly it's not an alternative to the standard approach that we've outlined.

Dr. Domino:

So, you've discussed the adverse effects of NSAIDs, especially in older patients, what are

the adverse effects and concerns with opioid prescribing?

Dr. Ehrlich:

Opioids can have a number of adverse effects. Certainly, constipation is extremely common in anyone who is on chronic opioid therapy. Other side effects can be somewhat more variable in how frequent they are, but patients may develop significant pruritus, you can certainly get nausea and vomiting. One particularly interesting adverse effect is hyperalgesia, where the skin becomes incredibly sensitive to touch, and so, a medicine that is designed to relieve their pain makes them very much more sensitive to pain than they otherwise would be. In addition, obviously, if it's taken to an excess, you have problems with respiratory depression and even death. We're right in the midst of an opioid crisis in that regard in this country. And even if your patient is doing fine, there's certainly the risk of diversion, where someone might take their medication and either sell it or use it themselves. And again, when used on a long-term basis, there's going to be the development of physical dependence on the opioids.

Dr. Domino:

Alan, I think what you brought forward is a great interpretation of this study, that shows chronic opioids probably are less ideal than other methods to initially address the pain of osteoarthritis of a lower extremity, but may have a role down the road when all else fails or in an as-needed approach.

Dr. Ehrlich:

Yeah, I think this study... Again, it's limited because the group that got the opioids did not have the benefit of other medicines that you would typically use in practice, such as antidepressants for chronic pain. Certainly, any of my patients who would have chronic lower back pain, I would make sure that they were getting either gabapentin or

amitriptyline or something like that on a long-term basis prior to even thinking about something like opioids. Obviously, some of those antidepressants, such as amitriptyline, have their own problems and side effects and have their own adverse problems in elderly patients. There's no perfect solution. But I do think one thing I would take away from the study is the notion that maybe the role of opioids in chronic pain is on a more as-needed basis, and to educate patients about that fact that, when used chronically, they are associated with a bunch of problems. When I talk to patients who are on opioids for chronic pain conditions, I try and tell them, "The less you use it, the better it works." That, "It has it's most impact immediately in the first day or two when you're using it, and then it tends to... Your body becomes accustomed to it. If you use it briefly and then you're using it on an intermittent basis, it's often gonna be very effective in those situations."

Dr. Domino:

Alan, thanks so much, this was a great discussion. Practice pointer, non-pharmacologic and non-opioid therapies are first and second line treatments for chronic pain, and especially of osteoarthritis of the lower extremities. Consider opioids as add-on therapy and on as a PRN basis. Join us next time when we discuss biomarkers for forms of dementia and in particular, Alzheimer's disease, and their role in clinical practice.